Children's Special Health Services Referral Form
(Please attain all of the following Information before returning this form to CSHS)

Callers Name: _____ **Who took Call:** _____
Date: _____
Phone Number: _____
Referral Type: ☐ Children's Special Health Services ☐ Eastern Region Specialty Clinic (Billings)
☐ Western Region Specialty Clinic (Missoula) ☐ South Central Region Specialty Clinic (Helena)
☐ Central Region Specialty Clinic (Great Falls) in development

Patient Name: _____ **DOB:** _____ **SS#:** _____ **Gender:** _____
Mother Name: _____ **Father Name:** _____
Legal Guardian if different than above: _____
Address: _____ **City/State:** _____ **Zip:** _____
Home Number: _____ **Work Number:** _____
Message Number: _____ **Cell Phone:** _____
E-mail Address: _____

Diagnosis: _____
Medications: _____
Allergies: _____

Physician: _____ **Specialist:** _____
Dentist: _____ **Orthodontist:** _____
Therapist: _____ **School:** _____

Health Coverage: ☐ CHIP ☐ Children's Special Health Services ☐ Medicaid Pending
☐ Caring Program ☐ Self Pay ☐ Medicaid Spend Down
☐ IHS ☐ Medicaid ☐ Other _____
☐ Private Health Insurance (Company Name): _____

Other Assistance Types: ☐ Social Security Supplement ☐ Children's Special Health Services
☐ Women Infants & Children Nutrition Program (WIC) ☐ Part C
☐ Other _____

CSHS Application mailed or given to Family? ☐ Yes ☐ No _____
Most Current Medical Notes Requested? ☐ Yes (date requested) _____
☐ Parent/Guardian will send Medical Notes to CSHS with Application
☐ Other _____

Clinic Referral – please complete this section of this form

Clinic Location: ☐ Billings ☐ Bozeman ☐ Browning ☐ Crow Agency ☐ Great Falls
☐ Helena ☐ Kalispell ☐ Missoula ☐ Wolf Point ☐

Clinic Type: ☐ Cardiac ☐ Developmental ☐ Gastrointestinal ☐ Metabolic ☐ NICU
☐ Cerebral Palsy ☐ Down Syndrome ☐ Genetics ☐ MS ☐ Pulmonary
☐ Cleft/Craniofacial ☐ Diabetes ☐ Hemophilia ☐ Neurology ☐ Rehab
☐ Cystic Fibrosis ☐ Endocrine ☐ JRA ☐ Neuro Tube ☐ Rheumatology

Clinic Season: ☐ Winter ☐ Spring ☐ Summer ☐ Fall **Year:** _____

Most Current Medical Notes Requested? ☐ Yes (date requested) _____
☐ Parent/Guardian will bring Medical Notes to Clinic
☐ Other _____

General Information:

Start Over

Print Form

Mail or Fax the completed referral form to: Children's Special Health Services, PO Box 202951, Helena MT 59620-2951
(406) 444-3622 or (800) 762-9891
Fax: (406) 444-2750